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No. 10-159

In The
Supreme Court of the United States

ARIZONA ASSOCIATION OF PROVIDERS FOR PERSONS WITH DISABILITIES, *et al.*,

Petitioners,

v.

THE HONORABLE J. KENNETH MANGUM,

Respondent,

STATE OF ARIZONA, *et al.*,

Real Parties In Interest.

On Petition For A Writ Of Certiorari To The Arizona Court Of Appeals, Division One

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Longstanding federal law requires states accepting Medicaid funding to provide methods and procedures to assure adequate reimbursement to providers. 42 U.S.C. § 1396a(a)(30)(A) ("§ 30"). Adequate reimbursement is intended to assure service quality and availability for beneficiaries. Section 30 preempts state laws and is privately enforceable.

In this case, the Arizona Court of Appeals interpreted § 30 to not apply to managed care organizations ("MCOs"). Nothing in § 30 or in any other federal statute, however, exempts MCOs from § 30's requirements. MCOs now provide services to about 70% of Medicaid beneficiaries nationwide and to nearly all of Arizona's developmentally disabled.

Petitioners ask this Court to review:

1. Whether § 30 applies to MCO rates.
2. If not, whether § 30 applies when the state agency MCO rates are cut solely due to the state's budget problems.

LIST OF PARTIES

Petitioners are the Arizona Association of Providers for Persons with Disabilities, an Arizona nonprofit corporation; Beverly Hermon, individually and as legal guardian for Eric Hermon; Toni McCleod, as legal guardian for E.K. and R.K.; Reeves Foundation, LLC, an Arizona limited liability company; ABRiO Family Services and Supports, Inc., an Arizona corporation; Family Partners, LLC, an Arizona limited liability company; and Metro Care Services, Inc., an Arizona corporation.

Respondent Judge is the Honorable J. Kenneth Mangum, Judge of the Superior Court of Maricopa County.

Respondents Real Parties in Interest are the State of Arizona, Neal Young in his official capacity as Director of the Arizona Department of Economic Security, and Thomas Betlach in his official capacity as Director of the Arizona Health Care Cost Containment System Administration.

RULE 29.6 CORPORATE DISCLOSURE STATEMENT

Petitioners do not have parent companies, and there are no publicly held companies that hold any stock of any petitioner except for the following:

Petitioner Metro Care Services, Inc. is wholly owned by TBC Services, LLC, an Arizona limited liability company. There are no publicly held companies that hold any stock in Metro Care Services, Inc. or TBC Services, LLC.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners petition for a writ of certiorari to review and reverse the decision of the Arizona Court of Appeals, Division One.

OPINIONS BELOW

This petition seeks review and reversal of the decision of the Arizona Court of Appeals, which is unreported. App., *infra*, 1-4. The Arizona Supreme Court denied review of the decision. App., *infra*, 9.

STATEMENT OF JURISDICTION

The Decision Order of the Arizona Court of Appeals was entered on April 1, 2010. *See* App., *infra*, 1. The Arizona Supreme Court denied petitioners' timely petition for review on May 20, 2010. App., *infra*, 9-10. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Relevant provisions of the Medicaid Act state in pertinent parts:

42 U.S.C. § 1396a(a)(30)(A)

> A State plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396u-2(b)(5)

> Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization –
>
> > (A) Offers an appropriate range of services and access to preventative primary care services for the population expected to be enrolled in such service area, and
> >
> > (B) maintains a sufficient number, mix, and geographic distribution of providers of services.

42 U.S.C. § 1396u-2(c)(1)(A)(i) and (ii)

> If a State provides for contracts with medicaid managed care organizations under section 1396(m) of this title, the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following:
>
> (i) Access standards
>
> Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialist services capacity.
>
> (ii) Other measures
>
> Examination of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards).

STATEMENT

A. Introduction

Federal Medicaid law requires each state to assure that provider payments are adequate to provide beneficiaries with services that are accessible and of good quality. This requirement is contained in 42 U.S.C. § 1396a(a)(30)(A) ("§ 30"). It is undisputed

that § 30 applies to Medicaid fee-for-service programs. However, relying on the Centers for Medicare and Medicaid Services ("CMS")[1] comments on proposed regulations, the Arizona Court of Appeals ruled that § 30 does not apply to Medicaid "managed care organizations" ("MCOs"). This is important because nationally and in Arizona, the vast majority of Medicaid beneficiaries are served under managed care instead of fee-for-service systems. As a result of this ruling, the State of Arizona ("State") jeopardized its provider network and services to thousands of beneficiaries with developmental disabilities when it cut Medicaid reimbursement rates by 10% solely due to the State's budget problems. The State ignored § 30's requirements, including established methods and procedures for setting rates, and directly interfered with the State's sole-source-MCO's rates for non-Medicaid reasons.

Petitioners are Medicaid beneficiaries, their guardians, and providers. The beneficiaries are persons with developmental disabilities (mental retardation, cerebral palsy, autism, epilepsy and related complications) who require long-term care to address their severe functional impairments. They are at risk of institutionalization in the absence of the home and community based services that petitioners provide. Respondents Real Parties in Interest are the State

[1] CMS is an agency of the United States Department of Health and Human Services.

of Arizona and the Directors of two state agencies, the Arizona Health Care Cost Containment System Administration ("AHCCCS") and the Arizona Department of Economic Security ("DES"). The State contracts with CMS for federal Medicaid funding. AHCCCS is the single state agency accountable to CMS for Medicaid compliance.

DES is the state agency that serves all Medicaid beneficiaries with developmental disabilities in Arizona. Ariz. Rev. Stat. § 36-2940. DES contracts with AHCCCS for the federal funding and AHCCCS delegates compliance with "applicable" Medicaid laws to DES.

DES wears two hats. It is an MCO under the State's Medicaid program and contracts with independent providers to provide services to beneficiaries. DES is also a state agency that sets uniform published rates at which it pays providers on a fee-for-service basis. The rates are established through a statutory procedure. Ariz. Rev. Stat. § 36-2959(A). When the Arizona Legislature reduced appropriations to DES because of the State's budget problems, DES cut its provider reimbursement rates by 10% without first studying the effects of reductions on quality of care and availability of services.

The Court of Appeals decision that § 30 does not apply to MCOs generally or to DES is incorrect. This Court should grant certiorari to correct that error.

B. Facts

DES announced in February 2009 that it was reducing Medicaid provider reimbursement rates by 10% across-the-board. In fact, the rates needed to be *increased* in order to assure quality and accessibility. Only months before the cuts, the DES rates analyst had warned DES about the Arizona Legislature's determination at that time to "freeze" DES rates and not to allow adoption of higher, recommended rates:

> We also do not see this (presumably temporary) situation as automatically violating any of the Title XIX principles of economy and efficiency, nor of denying consumer's access to providers. **However, should the freeze continue for an extended period, there would eventually be a deleterious impact on adequacy, appropriateness, access and/or quality of care for consumers. As such, an extended rate freeze period should be avoided.**

DES is required by state statute to conduct a "complete study" of reimbursement rates every five years. Ariz. Rev. Stat. § 36-2959(A). On February 1, 2009, DES released a voluminous rate report by Consultant Work Group. The report followed public forums involving providers and consumers. The DES report proposed rate increases for most services. On February 13, 2009, however, DES notified providers that DES was cutting rates 10% across-the-board because of the state's budget problems. In short, DES

abandoned its own process and methodology for rate setting.

Four days later, DES acknowledged it could not comply with its own caseload and service requirements under its MCO contract with AHCCCS, including "case management, timeliness, monitoring, medical, quality management, and business deliverable requirements" because of the funding reduction.

DES cut provider rates on May 25, 2009. A few months later, DES' rates analyst reported that he could not assure that the reduced rates were adequate.

Petitioners sued under the Supremacy Clause of the United States Constitution to require DES to comply with § 30. The Second Amended Complaint asserts that DES must first reasonably determine the effects of the proposed cuts on efficiency, economy, quality of care and availability of services before cuts are implemented. DES did not do this and slashed its rates to dangerous levels.

Petitioners applied for a preliminary injunction in February 2010 to restore full rates retroactive to implementation of the cuts. Through affidavits providers described their financial losses, internal cuts including wage reductions, and prospective inabilities to provide services. Petitioners' actuarial expert testified that reduced rates were inadequate to reimburse provider costs to deliver services and that the provider network was not sustainable. Nevertheless, the trial court dismissed petitioners' § 30 claim and the

Arizona Court of Appeals affirmed on interlocutory review, stating:

> Petitioners, who are service providers and Medicaid beneficiaries (through their legal guardians), do not have an equal access claim under § 30 against a managed care organization ("MCO"). *See generally G. v. Hawaii*, ___ F. Supp. 2d ___, 2009 WL 5061578 (D. Haw. Dec. 23, 2009); Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40,989, 41,036 (June 14, 2002); *see Ariz. Ass'n of Providers for Persons with Disabilities v. State*, 223 Ariz. 6, ___, ¶ 42, 219 P.3d 216, 227 (App. 2009) (per curiam).

See App., *infra*, 3.

The Arizona Supreme Court notified the parties on May 21, 2010 that it denied review on May 20, 2010. *See* App., *infra*, 9.

The Court of Appeals erred. Section 30 should apply, and does apply, to services under Arizona's state plan for Medicaid, which include the services in question. The text of § 30 and subsequent Medicaid enactments do not suggest any intent on the part of Congress to exclude the application of § 30 to MCOs. Section 30 requires the State to carefully study the effects of proposed rate reductions on service quality and continuing availability before cuts are implemented. DES chose expedience and slashed its rates for non-Medicaid reasons.

REASONS FOR GRANTING THE PETITION

A. This Case Augments the Pending Certiorari Petitions in Nos. 09-958 and 09-1158.

This case parallels petitions for writs of certiorari filed by the State of California to review Ninth Circuit interpretations of § 30.[2] This Court asked the Solicitor General to express the position of the federal government in *Independent Living Center* and held the petition in *California Pharmacists*.

This case concerns a broader application of § 30 that is not raised in the California petitions; i.e., managed care. The California cases concern the Medicaid fee-for-service system, which is the traditional Medicaid framework where the state pays service providers directly for services they provide to Medicaid beneficiaries. Under a managed care model, the states contract with MCOs that assume responsibility for delivering services through their own staff, subcontracting providers, or both. *See* App., *infra*, 14-15.

It is undisputed that § 30 applies to Medicaid fee-for-service rates paid by the states. What § 30 requires is the subject, in part, of California's petitions.

This case presents the question of whether § 30 applies to MCO rates when a state delegates

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[2] *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal., et al.*, No. 09-958 (hereinafter, "*Independent Living Center*"); *Maxwell-Jolly v. California Pharmacists Ass'n, et al.*, No. 09-1158 (hereinafter, "*California Pharmacists*").

Medicaid responsibilities to MCOs. Given that nationally 70% of Medicaid beneficiaries, or 33 million people, are served currently through managed care (90% in Arizona) and that there is an upward trend toward utilizing managed care, this is a timely question. Medicaid Managed Care Enrollment as of December 31, 2008, available at https://www.cms.gov/MedicaidDataSourcesGenInfo/05_MdManCrPenRateandExpEnrll.asp (last visited July 26, 2010). With state legislatures such as Arizona's cutting state matching appropriations for Medicaid programs, this is a poignant moment to clarify the limits of state actions to make cuts in cooperative federal-state programs after the states accept the federal dollars.

Petitioners believe that *Independent Living Center* was correctly decided by the Ninth Circuit and that its reasoning should be applied to DES. If the Court denies California's petition, petitioners believe it should grant review of this case to consider the applicability of § 30 to MCOs. If the Court grants review of California's petition, it should grant review of this case as well and consolidate the cases for argument. Petitioners ask the Court to consider inviting the Solicitor General for advice about this case, just as it has in the California case.

B. By Holding that § 30 Does Not Protect the 70% of Medicaid Beneficiaries Who Are Enrolled in Managed Care Plans, the Arizona Court of Appeals Erroneously Resolved an Important Question of Federal Law.

1. The Executive Branch Erred to the Extent It Concluded that § 30 Has No Application to Managed Care Plans.

The Court of Appeals decision fundamentally rests upon comments by CMS in the Federal Register in 2002 regarding the agency's proposed managed care regulations. CMS stated, in relevant part:

> Section 1902(a)(30)(A) is a requirement that applies to the State's fee-for-service program, operated pursuant to the State plan. The provision that specifically governs the availability of services under a State's managed care program is Section 1932(c)(1)(A)(i) of the Act which requires that services be available "in a manner the ensures continuity of care and adequate primary and specialized services capacity." We believe that the provisions of § 438.206(b)(1) carry out the intent of Congress under Section 1932 to provide access standards that will ensure the availability of care in MCOs. . . .

67 Fed. Reg. 41,036 (June 14, 2002); *see* App., *infra*, 24.

CMS explained that it does not regulate payments between MCOs and subcontracting providers

because, in its view, Congress has not established standards for payment to subcontractors.

> We believe that this is because one of the efficiencies of managed care is premised on an MCO's ability to negotiate favorable payment rates with network providers. MCOs must pay sufficient rates to guarantee that their networks meet the access requirements in subpart C of this final rule. We believe that payment rates are adequate to the extent the MCO has documented the adequacy of its network.

67 Fed. Reg. 40,998 (June 14, 2002); *see* App., *infra*, 16.

The text of § 30 does not say (or even imply) that the statute's reach is limited to fee-for-service payments or only to payments by the state Medicaid agency. The statute expressly applies to "services available under the plan," which include the DES services in question.

The Medicaid program established by Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, is a cooperative federal-state program to provide medical care to needy individuals. *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498, 502 (1990); *Atkins v. Rivera,* 477 U.S. 154, 156 (1986). State participation in Medicaid is voluntary, but those States that elect to participate must comply with requirements imposed by the Medicaid Act and by the Secretary of Health and Human Services in her administration of the Act. *See* 42

U.S.C. § 1396a; *Wilder*, 496 U.S. at 502; *Rivera*, 477, U.S. at 157.

To qualify for federal funds, participating states must submit to the Secretary, and receive approval of, "a plan for medical assistance" detailing the nature and scope of the state's Medicaid program. 42 U.S.C. § 1396a(a); 42 C.F.R. § 430.10 (1996); *Wilder*, 496 U.S. at 502. Among other requirements, a state's plan must comply with § 30.

In the text of § 30 itself, Congress recognized the connection between adequate payments on the one hand and accessible services of good quality on the other. The assurances are no less necessary when service providers are paid by MCOs than when they are paid directly by state Medicaid agencies, and especially when Medicaid is the only purchaser of such services.

Congress enacted the Balanced Budget Act of 1997, which includes Medicaid amendments. 42 U.S.C. § 1396u-2 allows states to contract with Medicaid MCOs, provided that each MCO demonstrates adequate capacity and services (§ 1396u-2(b)(5)) and that the state develops strategies to assure the accessibility of services and quality of care delivered by MCOs (§ 1396u-2(c)(1)(A)(i) and (ii)). Section 1396u-2 does not mention payments for services, and Congress did not amend § 30 when enacting § 1396u-2. Nothing in the legislative history indicates that Congress intended that § 30 not apply to MCOs. In fact, history shows just the opposite.

42 U.S.C. § 1396a(a) lists the many required "Content" provisions in "State plans for medical assistance." When Congress in 1997 added the "state option to use managed care" in § 1396u-2, Congress expressly excepted some paragraphs of § 1396a(a) – *i.e.*, paragraphs (1), (10)(b), and (23)(A) of § 1396a(a) – but not paragraph (30)(A). *See* 42 U.S.C. § 1396u-2(a)(1)(A).

As a state agency DES reacted to non-Medicaid factors when it slashed its Medicaid rates by 10%. Indeed, even before the rate cuts DES was prevented from implementing upward rate adjustments when the Arizona Legislature "froze" the then-existing rates.

The Ninth Circuit decided that budgetary considerations could not be the sole reason for Medicaid rate cuts in California and that rates reduced so arbitrarily, without reference to § 30 requirements, are unlikely to meet accessibility and quality requirements. Plaintiffs in *Independent Living Center* were a group of health care providers and Medicaid beneficiaries who sought to enjoin state officials from implementing a 10% rate cut in California's fee-for-service program. *Indep. Living Ctr. of S. Cal. v. Maxwell-Jolly,* 572 F.3d 644, 648-49 (9th Cir. 2009). The officials responsible for implementing the rate cuts did not rely on any cost studies, maintain information on provider costs for covered services, or provide any evidence that the agency or the legislature studied the impact of the rate reductions before implementation. *Id.* The Ninth Circuit decided that this circumstance violated § 30 and upheld the district court's injunction. "A budget crisis does not

excuse ongoing violations of federal law, particularly when there are no adequate remedies available other than an injunction . . . [T]here is a robust interest in safeguarding access to health care for those eligible for Medicaid, whom Congress has recognized as 'the most needy in the country'" *Id.* at 659.

Other recent cases from the Ninth Circuit are instructive. These cases are also before this Court on California's petition for writ of certiorari in No. 09-1158. In *California Pharmacists Association v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010), the Medi-Cal agency contended that the state legislature by-passed the agency and set the rates itself, implementing a 5% rate cut. The Ninth Circuit rejected this circumvention of the "equal access" provision:

> [W]e find nothing remarkable in holding that the final body responsible for setting Medicaid reimbursement rates must study the impact of the contemplated rate reduction on the statutory factors of efficiency, economy, quality of care, and access to care *prior to* setting or adjusting payment rates . . . in no way do we mean to suggest that the State is proscribed from setting or adjusting reimbursement rates. We simply reaffirm that if it does so, it must comply with federal law.

Cal. Pharmacists Ass'n, 596 F.3d at 1107.

The court went on to say that a rate adjusted arbitrarily due to budget cuts, without reference to the requirements of § 30, will not meet the procedural

requirements of federal law and is unlikely to meet the substantive requirements. *Id.* at 1111-12.

In *Dominguez v. Schwarzenegger*, 596 F.3d 1087 (9th Cir. 2010), the California legislature reduced the state's share of funding for certain in-home Medicaid services. The legislature did not mandate rate cuts but instead cut the available funding, leaving rate negotiations to other contractors. Nevertheless, the court easily recognized the direct link between the funding cut and the provider reimbursement cuts. In affirming the district court's preliminary injunction, the Ninth Circuit emphasized that "*de facto* access, produced by factors unrelated to reimbursement levels does not satisfy the requirement of [§ 30(A)]." *Dominguez*, 596 F.3d at 1095 (quoting *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997)). Plaintiffs were not required to prove a substantive violation of § 30 once they demonstrated that California failed to meet the procedural requirements. *Id.* at 1096.

Petitioners ask this Court to extend these rulings to Medicaid MCO rates and particularly to those of DES. Any way one looks at it, the State of Arizona sets and publishes uniform Medicaid fee-for-service rates for services for people with developmental disabilities. It does so through DES instead of AHCCCS. That DES is an MCO should not eviscerate § 30 requirements.

The Arizona Court of Appeals also cited *G. v. Hawaii*, 676 F. Supp. 2d 1046 (D. Haw. 2009), for

authority that § 30 does not apply to an MCO like DES. But the Arizona Court of Appeals and the district court in *G. v. Hawaii* cite one another for their decisions and their combined rationales boil down to reliance on CMS' comments in the Federal Register.

Hawaii replaced its Medicaid fee-for-service program by issuing requests for proposals for MCOs and awarding contracts to two private insurance companies. These MCOs had to compete to obtain the contracts and have to compete for providers and beneficiaries. At one point the district court explained,

> In a fee-for-service system, the traditional framework for state Medicaid programs, the state contracts directly with and pays healthcare providers . . . for services they provide to Medicaid beneficiaries . . . By contrast, under a managed care model, the state contracts with MCOs, which assume the responsibility of providing Medicaid services through their own employees or by contracting with independent providers of services . . . The state pays each MCO on a capitated or fixed-amount-per-enrollee basis.

G. v. Hawaii, 676 F. Supp. 2d at 1053. Both frameworks apply to DES. DES should not be regarded only as an MCO.

CMS' comments were wrong and, therefore, so are the decisions of the Court of Appeals and the District Court of Hawaii. The texts of these statutes neither say nor imply that § 30 applies only to fee-for-service rates paid by the state Medicaid agency. The

legislative histories do not support such a narrow construction either. Petitioners believe the statutes are intended to work together. Section 1396u-2 sets forth network standards that the state must require of each contracting MCO and requires the state to fund each MCO at capitation rates that are actuarially sound. These requirements provide a framework within which states can comply with § 30 through delegation to MCOs. Section 1396u-2 does not supplant § 30. MCOs provide services available under the state plan, to which § 30 applies. The requirements of § 30 prohibit the state from directly interfering in MCO operations and network management in the manner that occurred in this case – requiring provider payment rate cuts because of non-Medicaid considerations. And if the MCO is also an arm of state government, as with DES, § 30 prohibits that state government from reducing its agency rates solely due to the state's budget problems – just as the Ninth Circuit held in *Independent Living Center*.

2. Even If § 30 Does Not Apply to Private MCOs, It Must Be Applied to Fully-Public Entities that Respond to Budgetary Pressures and Not Market Forces.

The market factors that CMS envisioned would support adequate rates under managed care are not present in this case. DES is a state agency and operates more like a Medicaid fee-for-service program than a MCO. DES adopts provider payment rates

through a statutory process that produces uniform Medicaid fee-for-service rates. Unlike the MCOs in *G. v. Hawaii*, DES does not compete for its MCO contract. The Arizona Legislature mandates that DES be the statewide MCO. Ariz. Rev. Stat. § 36-2940. DES does not compete for beneficiaries or providers. It does not negotiate payment rates with providers. The market dynamics that led CMS to presume the adequacy of provider payment rates have not been present at all – before or after DES made the cuts.

Furthermore, in *G. v. Hawaii*, the state required contracting MCOs to use the state's existing fee-for-service rates (which presumably were established in compliance with § 30), as the *minimum* rates the MCOs could use to pay providers. *G. v. Hawaii*, 676 F. Supp. 2d at 1067 n. 18. When DES was forced to disregard existing rates and its statutory methods and procedures for setting rates, the state abandoned all pretense of following Medicaid requirements.

DES is a monopsony. Medicaid is the sole payer for the services at issue. The reduced rates have forced providers to make risky internal cuts and, ultimately, will cause providers to leave the program or go out of business. CMS plainly did not envision this scenario when it commented generally on the interplay between § 30 and § 1396u-2.

A CMS response to a public comment cannot change § 30. Deference to an agency's statutory interpretation is called for only when the "devices of judicial construction have been tried and found to

yield no clear sense of congressional intent." *General Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 600 (2004) (quoting *INS v. Cardoza-Fonseca*, 480 U.S. 421, 446, 107 S.Ct. 1207, 94 L.Ed.2d 434 (1987)); *see Kruse v. Wells Fargo Home Mortg., Inc.*, 383 F.3d 49, 55 (2d Cir. 2004).

Alternatively, if CMS is correct about § 30 and MCO rates generally, petitioners submit that the case of DES is different and that § 30 should apply. DES is a state agency and as such is subject to direct legislative control of its budget. DES' status as an MCO was irrelevant to the rate cuts. The Arizona Legislature cut DES appropriations and DES had to decide where to make its cuts in its various welfare programs (*e.g.*, child and adult protective services, foster care, developmental disabilities, among others). DES cut its rates due to non-Medicaid factors. There were no marketplace negotiations with providers. There was no planning. The existing methods and standards to create and adjust rates were ignored. DES simply announced it was cutting its uniform Medicaid rates due to the State's budget problems and it cut its rates at least twice as much as AHCCCS cut rates for services for other Medicaid beneficiaries.

All Medicaid beneficiaries with developmental disabilities are enrolled with DES. All providers wishing to serve such beneficiaries must contract with DES. There are no other payors – public, commercial or private. Further rate cuts are contemplated because of the State's budget problems. The rate reductions already threaten access to essential services.

Compliance with § 30 is an obligation of the State of Arizona. The Court of Appeals permitted the State to eviscerate § 30 by contracting with itself through two state agencies. To the extent the attenuation of relationships resulting from "down-stream" contracting is a factor in CMS' reasoning regarding the non-application of § 30 to MCO-provider rates, that dynamic is not present when the MCO is a state agency.

Although states may contract with private and public health care providers to deliver the panoply of services guaranteed under the Medicaid program, states retain ultimate responsibility to ensure compliance with the Medicaid Act. *See Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001) (describing state's duties under Medicaid Act as "non-delegable"); *J.K. By and Through R.K. v. Dillenberg*, 836 F. Supp. 694, 699-700 (D. Ariz. 1993) ("It is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity.").

C. The Protections of § 30 Are of Critical Human Importance to Developmentally Disabled Persons in Arizona and Throughout the United States.

In Arizona, 90% of Medicaid beneficiaries are served through MCOs, and that includes 100% (24,000 people) of beneficiaries in need of long-term care with developmental disabilities. Before the State first implemented its Medicaid program in 1982, 99%

of Medicaid beneficiaries nationally were served in fee-for-service programs. *See* App., *infra*, 14. Now, almost 70% of Medicaid beneficiaries (33 million people) are enrolled in managed care. Congress did not relieve the states of § 30 compliance when it granted states broader authority to utilize MCOs. Congress plainly could have done so when it enacted the Balanced Budget Act, and yet it did not. The protections of § 30 should not disappear for most Medicaid beneficiaries without direction from Congress, and not on the basis of CMS' comments.

Adequate rates are critical, especially for long-term care services for which Medicaid is the dominant, and sometimes the sole payor. And especially with such a vulnerable population. Similar to what occurs in other parts of the country, the Arizona Medicaid program is essentially the only purchaser of services for persons with developmental disabilities. As reported in the 2007 Health Care Financing Review,

> As a purchaser, Medicaid may be almost a monopsonist. Medicaid purchases almost all care for people with [mental retardation and developmental disabilities], most of the [Long Term Care] for people with physical disabilities, most of the care for people with AIDS, and much of the care for people with serious mental illness. In the absence of reference points from Medicare and private payers, States setting payment rates usually only have each other to look to. As previously noted, we would predict that Medicaid

> payment rates would cover a higher percentage of provider cost than when Medicaid is one among many payers in a market. Yet, in markets dominated by Medicaid it can be circular to compare costs and payments, because providers whose costs exceed Medicaid rates have trouble staying in business. Few studies exist on how Medicaid uses its purchasing power in these markets.

Kevin Quinn and Martin Kitchener, *Medicaid's Role in the Many Markets for Health Care*, 28 Health Care Fin. Rev. 69 (2007).

The beneficiaries are entitled to services. The MCOs and providers must still comply with Medicaid deliverables. In Arizona, they must do so now after losing 10% of their revenues and for less than the costs of delivering services, all due to State actions that have nothing to do with Medicaid.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

JOHN R. DACEY
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Counsel for Petitioners

July 29, 2010

NOTICE: THIS DECISION DOES NOT CREATE LEGAL PRECEDENT AND MAY NOT BE CITED EXCEPT AS AUTHORIZED BY APPLICABLE RULES.
See Ariz. R. Supreme Court 111(c); ARCAP 28(c); Ariz. R. Crim. P. 31.24

IN THE COURT OF APPEALS
STATE OF ARIZONA
DIVISION ONE

ARIZONA ASSOCIATION OF PROVIDERS FOR PERSONS WITH DISABILITIES, an Arizona nonprofit corporation; BEVERLY HERMON, individually and as legal guardian for Eric Herman; TONI McCLEOD, as legal guardian for E.K. and R.K.; REEVES FOUNDATION, LLC, an Arizona limited liability company; ABRIO FAMILY SERVICES AND SUPPORTS, INC., an Arizona limited liability company; METRO CARE SERVICES, INC., an Arizona corporation, Petitioners, v.	1 CA-SA 10-0031 DEPARTMENT B Maricopa County Superior Court No. CV 2009-006509 **DECISION ORDER** (Filed Apr. 1, 2010)

THE HONORABLE J. KENNETH MANGUM, Judge of the SUPERIOR COURT OF THE STATE OF ARIZONA, in and for the County of MARICOPA,

Respondent Judge,

STATE OF ARIZONA; NEAL YOUNG, in his official capacity as Director of the Arizona Department of Economic Security; and THOMAS BETLACH, in his official capacity as Director of the Arizona Health Care Cost Containment System Administration,

Real Parties in Interest.

JURISDICTION ACCEPTED; RELIEF DENIED

In this special action, petitioners ask us to reverse the superior court's dismissal of their "equal access" claim, *see* 42 U.S.C. § 1396a(a)(30)(A) ("§ 30"), against real parties in interest, State of Arizona and the Directors, named in their official capacities, of the Arizona Department of Economic Security ("DES") and the Arizona Health Care Cost Containment System ("AHCCCS"). Petitioners' equal access claim arises out of, first, a 10% reduction in rates paid by DES's Division of Developmental Disabilities

("Division"), to providers for home-and-community-based services for the developmentally disabled, and second, delays in payments made by the Division to its service providers.

Because proceedings in this case are ongoing, and an appeal would not present an equally plain and speedy resolution of petitioners' challenge to the superior court's dismissal of their § 30 claim,

IT IS ORDERED, the court, Presiding Judge Patricia K. Norris and Judges Daniel A. Barker and Peter B. Swann, participating, in the exercise of its discretion, accepts special action jurisdiction of this matter, but denies relief.

Petitioners, who are service providers and Medicaid beneficiaries (through their legal guardians), do not have an equal access claim under § 30 against a managed care organization ("MCO"). *See generally G. v. Hawaii,* ___ F. Supp. 2d ___, 2009 WL 5061578 (D. Haw. Dec. 23, 2009); Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40,989, 41,036 (June 14, 2002); *see Ariz. Ass'n of Providers for Persons with Disabilities v. State,* 223 Ariz. 6, ___, ¶ 42, 219 P.3d 216, 227 (App. 2009) (per curiam).

On the record presented, the superior court did not improperly dismiss petitioners' equal access claim against the state's MCO. We therefore deny the relief requested by petitioners. In so doing, however, we express no opinion on the effect of § 30, if any, on the

establishment or computation of capitation rates paid to MCOs.

/s/ _____
PATRICIA K. NORRIS,
Presiding Judge

SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CV 2009-006509 02/01/2010

HONORABLE J. KENNETH MANGUM
CLERK OF THE COURT D. Glab Deputy

ARIZONA ASSOCIATION OF PROVIDERS FOR PERSONS WITH DISABILITIES, et al.
JOHN R DACEY

v.

STATE OF ARIZONA, et al.
WILLIAM A RICHARDS
LOGAN T JOHNSTON

TRIAL MINUTE ENTRY
DAY ONE

(Filed Feb. 8, 2010)

Courtroom 514 – East Court Building

Defendants' exhibits 1 through 52, Plaintiffs' exhibits 53 through 61 and Defendants' exhibits 62 through 64 are marked for identification.

9:31 a.m. This is the time set for Trial to the Court on certain issues.

In Chambers: Plaintiffs are represented by counsel, John R. Dacey and James A. Craft. State Defendants are represented by counsel, William A. Richards and Nicole Davis. Defendant Betlach is represented by counsel, Logan T. Johnston.

Court Reporter, Amy Stewart, is present. Also, a record of the proceedings is made by audio and/or videotape.

Plaintiffs' Motion in Limine to Seal Documents or Information is argued.

IT IS ORDERED granting the Motion at this time.

10:03 a.m. Hearing in chambers concludes.

10:06 a.m. Respective counsel are present.

Court Reporter, Amy Stewart, is present. Also, a record of the proceedings is made by audio and/or videotape.

Defendant Betlach's Motion to Dismiss "Equal Access" claim is argued.

IT IS ORDERED granting Defendant Betlach's Motion to Dismiss "Equal Access" claim.

10:42 a.m. Court stands at recess.

10:54 a.m. Court reconvenes with respective counsel present.

Court Reporter, Amy Stewart, is present. Also, a record of the proceedings is made by audio and/or videotape.

Defendants Betlach's Motion in Limine Re Two Experts on One Subject is argued.

IT IS ORDERED denying Defendants' Motion to limit Plaintiffs' experts.

Defendant States' Motion to Deny the Preliminary Injunction Request and Vacate the Hearing is argued.

IT IS FURTHER ORDERED taking this matter under advisement.

Plaintiffs may file a written response within 48 hours.

The Rule of Exclusion of Witnesses is invoked by counsel, William Richards.

On stipulation, Plaintiffs' exhibits 53, 56, 57, 59 and 60, and Defendants' exhibit 1 are received in evidence.

Opening statements.

12:12 p.m. Court stands at recess.

Defendants' exhibits 65 and 66 are marked for identification.

1:34 p.m. Court reconvenes with respective counsel present.

Court Reporter, Amy Stewart, is present. Also, a record of the proceedings is made by audio and/or videotape.

The record will not be transcribed without further Court order.

Opening statements continue.

Plaintiffs' case:

Randall L. Gray is sworn and testifies.

2:59 p.m. Court stands at recess.

3:12 p.m. Court reconvenes with respective counsel present.

Court Reporter, Amy Stewart, is present. Also, a record of the proceedings is made by audio and/or videotape.

Plaintiffs' exhibit 54 is substituted for another copy without missing pages.

Randall L. Gray testifies further.

For purposes of this hearing and not for final trial, Plaintiffs' exhibit 54 is received in evidence.

Plaintiffs' exhibit 54 is substituted for another copy without missing pages.

Defendants' exhibit 64 is received in evidence.

Plaintiffs' exhibit 55 is received in evidence.

4:32 p.m. Court stands at recess until 9:30 a.m. on February 2, 2010.

[SEAL]

Supreme Court

RACHELLE M. RESNICK
CLERK OF
THE COURT

SUZANNE D. BUNNIN
CHIEF DEPUTY
CLERK

STATE OF ARIZONA

**402 ARIZONA STATE
COURTS BUILDING**

**1501 WEST WASHINGTON STREET
PHOENIX, ARIZONA,
85007-3231**

**TELEPHONE:
(602) 452-3396**

May 21, 2010

RE: AZ ASSOC/HERMON et al v HON. MAGNUM/STATE et al
Arizona Supreme Court No. CV-10-0113-PR
Court of Appeals Division One No. 1 CA-SA 10-0031
Maricopa County Superior Court No. CV2009-006509

GREETINGS:

The following action was taken by the Supreme Court of the State of Arizona on May 20, 2010, in regard to the above-referenced cause:

ORDERED: Petition for Review = DENIED.

Record returned to the Court of Appeals, Division One, Phoenix, this 21st day of May, 2010.

Rachelle M. Resnick, Clerk

TO:
John R. Dacey
William A. Richards
Logan T. Johnston III
Hon. J. Kenneth Mangum
Philip G. Urry
sj

Federal Register/Vol. 67, No. 115/
Friday, June 14, 2002/Rules and Regulations

[40989]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 400, 430, 431, 434, 435, 438, 440, and 447

[CMS-2104-F]

RIN 0938-AK96

Medicaid Program; Medicaid Managed Care: New Provisions

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule amends the Medicaid regulations to implement provisions of the Balanced Budget Act of 1997 (BBA) that allow the States greater flexibility by permitting them to amend their State plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without obtaining waivers if beneficiary choice is provided; establish new beneficiary protections in areas such as quality assurance, grievance rights, and coverage of emergency services; and eliminate certain requirements viewed by State agencies as impediments to the growth of managed care programs, such

as, the enrollment composition requirement, the right to disenroll without cause at any time, and the prohibition against enrollee cost-sharing.

EFFECTIVE DATE: These regulations are effective on August 13, 2002. States will have until June 16, 2003, to bring all aspects of their State managed care program (that is, contracts, waivers, State plan amendments and State operations) into compliance with the final rule provisions.

FOR FURTHER INFORMATION CONTACT:

Subparts A and B – Bruce Johnson, (410) 786-0615.

Subpart C – Kristin Fan, (410) 786-4581.

Subpart D – Deborah Larwood, (410) 786-9500.

Subpart F – Tim Roe, (410) 786-2006.

Subpart H – Donna Schmidt, (410) 786-5532.

Subpart I – Tim Roe, (410) 786-2006.

Subpart J – Bruce Johnson, (410) 786-0615.

SUPPLEMENTARY INFORMATION:

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I. Background

A. General

In 1965, amendments to the Social Security Act (the Act) established the Medicaid program as a joint Federal and State program for providing financial assistance to individuals with low incomes to enable them to receive medical care. Under the Medicaid program, each State establishes its own eligibility standards, benefits packages, payment rates and program administration in accordance with certain Federal statutory and regulatory requirements. The provisions of each State's Medicaid program are described in the State's Medicaid "State plan" that we must approve. In addition to approving State plans and monitoring States for compliance with Federal Medicaid laws, the Federal role also includes providing matching funds to State agencies to pay for

a portion of the costs of providing health care to Medicaid beneficiaries. Medicaid beneficiaries typically include low-income children and their families, pregnant women, individuals age 65 and older, and individuals with disabilities. (Throughout this preamble, we use the term "beneficiaries" to mean "individuals eligible for and receiving Medicaid benefits." The term "recipients" in the regulations text has the same meaning as the term "beneficiary.")

When the Medicaid program was created, coverage typically was provided through reimbursements by the State agency to health care providers who submitted claims for payment after they provided health care services to Medicaid beneficiaries. This reimbursement arrangement is referred to as "fee-for-service" (FFS) payment. Before 1982, 99 percent of Medicaid beneficiaries received Medicaid coverage through fee-for-service arrangements. Since 1982, State agencies increasingly have provided Medicaid coverage through contracts with managed care organizations (MCOs), such as health maintenance organizations (HMOs). Through these contracts an MCO is paid a fixed, prospective, monthly payment for each beneficiary enrolled with the entity for health coverage. This payment approach is referred to as "capitation." Beneficiaries enrolled in capitated MCOs are required to receive health care services provided under the MCO's contract, through the MCO that receives the capitation payment. The Omnibus Budget Reconciliation Act (OBRA) of 1981 (Pub. L. 97-35 enacted on August 13, 1981) allowed State

agencies to mandate that Medicaid beneficiaries enroll in MCOs, which increased the use of MCOs. In most States, mandatory enrollment takes place for at least certain categories of beneficiaries. To achieve this mandatory enrollment, before the enactment of the Balanced Budget Act (BBA) of 1997 (Pub. L. 105-33, enacted on August 5, 1997), States were required to obtain a waiver of a Medicaid statutory requirement for beneficiary "freedom of choice" of providers. (State programs that offered beneficiaries voluntary enrollment in MCOs do not require these waivers.) As a result, in 1997, just before the passage of the BBA, almost 8.5 million Medicaid beneficiaries, or 43 percent of all Medicaid beneficiaries, were enrolled in MCOs for a comprehensive array of Medicaid services. Some of these beneficiaries and additional Medicaid beneficiaries were enrolled in other organizations that received capitated payment for a limited array of services, such as behavioral health or dental services. These organizations that receive capitation payment for a limited array of services are referred to as "prepaid health plans (PHPs)."

While the Act was further amended in the 1980s and in 1990 to address certain

* * *

[40998] rely on an actuarial certification that the data used had sufficient validity for this purpose. For the retention of FFS data in general, § 433.32(b) and (c) require States to retain records, such as FFS data, for 3 years from the date of submission of a final

expenditure report (or longer of audit findings have not been resolved). We believe that these data have value for rate setting purposes beyond the time period they are required to be retained under that regulation.

Comment: One commenter suggested that requirements for actuarial soundness extend to payment rates between MCOs and subcontracting providers.

Response: Except in the case of payments to FQHCs that subcontract with MCOs, which are governed by section 1903(m)(2)(A)(ix), we do not regulate the payment rates between MCOs and subcontracting providers. While section 1903(m)(2)(A)(iii) requires that payments to MCOs be actuarially sound, other than in the case of FQHCs, the Congress has not established any standards for payments to subcontractors. We believe that this is because one of the efficiencies of managed care is premised on an MCO's ability to negotiate favorable payment rates with network providers. MCOs must pay sufficient rates to guarantee that their networks meet the access requirements in subpart C of this final rule. We believe that payment rates are adequate to the extent the MCO has documented the adequacy of its network.

Definition of Actuarially Sound Capitation Rates

Comment: Many commenters believed that CMS should go beyond simply defining an actuarially sound process, and instead should establish prescriptive

standards for actuarial soundness. Some commenters believed that the definition of "actuarially sound capitation rates" should include the concept that rates be sufficient to cover the reasonable costs of the MCO. Other commenters suggested that we adopt the definition of actuarial soundness adopted by the Health Committee of the Actuarial Standards Board in the context of the small group market, which requires that payments "are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital. Another commenter believed the definition of actuarially sound rate setting should be replaced with language similar to the following: rates are determined using generally accepted actuarial methods based on analyses of historical State contractual rates and an MCO's experience in providing heath care for the eligible populations, and are paid based on legislative allocations for the Medicaid program. Several other commenters supported our proposed approach requiring that rates be developed using accepted actuarial principles and practices.

Response: As discussed in detail below, we considered various approaches in defining actuarial soundness, but decided that basing the definition on a methodology that uses accepted actuarial principles and practices, and that is certified by a member of the American Academy of Actuaries, is the best approach in that it gives States and actuaries maximum

flexibility while still ensuring that rates be certified as actuarially sound.

Comment: A number of commenters wanted the actuarial soundness test at § 438.6(c)(1)(i) to be revised to require that payment rates be adequate to cover the actual cost of services to be provided, and wanted us to take a more active role in assuring the adequacy of rates, including; (1) Reviewing key components and underlying assumptions of the rates, rather than accepting an actuary's certification; (2) ensuring proper adjustment and enforcement of the payment rules; (3) disapproving rates determined to be inadequate; (4) requiring disclosure of rate calculation inputs; and (5) resolving rate calculation disputes between MCOs and States. In contrast, several other commenters believed that we had gone too far in establishing a standard for rate adequacy that would be difficult to administer and justify.

Response: While, as indicated above, there was a consensus among commenters on the need to replace the UPL requirement, there were a wide variety of opinions among commenters on requirements to replace it. In the proposed rule, we sought to strike a balance between merely accepting State assurances on capitation rates in risk contracts on one hand, and requiring that the amounts of the capitation rates paid in each contract meet specific requirements for reasonableness and adequacy on the other. Under the former concept, we did not believe that we would meet our statutory responsibility to ensure that rates are actuarially sound as

required under section 1903(m)(2)(A)(iii). Under the latter format, we would be establishing standards for reasonableness and adequacy of rates, which: (1) Would require that a determination be made on every rate cell in each risk contract submitted to us for review; (2) would require that we obtain sufficient actuarial expertise to review every risk contract in Medicaid managed care; and (3) would establish a new "reasonable and adequate" payment standard for Medicaid managed care when, in the BBA, the Congress amended title XIX to eliminate a similar requirement for Medicaid payments to institutional providers.

As a result of these considerations, we have established a requirement that payment rates in risk contracts be actuarially sound, that is, that they have been developed in accordance with generally accepted actuarial principles and practices, are appropriate for the populations and services under the contract, and have been certified by an actuary as meeting the requirements in this rule and the standards of the Actuarial Standards Board. This rule then sets forth the basic requirements that States must apply in setting capitation rates, and the documentation that States must provide to us to support their rate setting process. We believe that by reviewing the process used in setting the rates under a risk contract, we will fulfill our regulatory responsibilities to the fiscal integrity of the Medicaid program and will assure that States have considered all relevant factors in this process. We believe that MCOs, PIHPs, and

PAHPs, that contract with States on a risk basis, are better able to determine whether rates are reasonable and adequate, and will do so in deciding whether or not to agree to contract or continue to contract with a State to provide services as part of a Medicaid managed care program.

Comment: A commenter believed that we should acknowledge that actuarially sound rates may vary between MCOs in the same service area.

Response: We acknowledge that rates may differ between MCOs in the same area for a variety of reasons, but most often when States utilize risk adjustment based upon health status or diagnosis.

Comment: One commenter asked whether the actuarial soundness requirement applies only to capitation rates under an entire contract, or to each rate cell under the contract.

Response: The requirement in proposed § 438.6(c)(2)(i) that *all* capitation rates paid under risk contracts and all risk sharing mechanisms in the contracts must be actuarially sound applies this requirement to all rate cells, as well as the entire contract, and all payments made under the contract. This is a change from the UPL requirement where individual rate cells within the contract

* * *

[41036] services; (4) the number of network providers who are not accepting new patients; and (5) the geographic location of providers and enrollees, considering

distance, travel time, the means of transportation normally used by enrollees, and whether the location provides physical access for enrollees with disabilities.

In § 438.206(b)(2) we proposed that the State be required to ensure that MCOs and PIHPs allow women direct access to a woman's health specialist for women's routine and preventative services. Proposed § 438.206(b)(3) required that MCOs and PIHPs provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee. In paragraph (4), we proposed that the MCO or PIHP must cover medically necessary services for enrollees obtained outside the network if, and for as long as, they cannot be obtained from within the network. Paragraph (5) of the proposed rule required out-of-network providers to coordinate with the MCO and PIHP with respect to payment and ensure that the cost to the enrollee is no more than it would be if the services were provided within the network. In paragraph (6), we proposed that MCOs and PIHPs demonstrate that their providers are credentialed in accordance with § 438.214(b).

Paragraph (c)(1) required MCOs and PIHPs to meet State standards for timely access to services and to require that their providers also meet these standards. It also required MCOs and PIHPs to (1) ensure that network providers offer hours of operation that are no less than the hours of operation offered to

commercial enrollees or comparable Medicaid fee-for-service, if the provider serves only Medicaid enrollees; (2) make services available 24 hours a day, 7 days a week, when medically necessary; (3) establish mechanisms to ensure compliance with these requirements; (4) monitor for compliance continuously; and (5) take corrective action if there is a failure to comply.

Paragraph (c)(2) required that the State ensure that each MCO and PIHP participate in State efforts to promote the delivery of services in a culturally competent manner to all enrollees with limited English proficiency and diverse cultural and ethnic backgrounds.

Comment: Many commenters said that the provisions in proposed § 438.206 should apply to all PHPs because PAHPs should have the same requirements for an adequate provider network as applies to MCOs and PIHPs. One commenter said that this section should apply to dental plans.

Response: We agree with the commenters that the availability of services provisions should apply to PAHPs. Therefore, in § 438.206 of the final rule, we have added "PAHP" in each instance in which the terms "MCO or PIHP" appeared in the proposed rule, Therefore, these requirements will now apply to dental PAHPs. We note that the types of providers that a PAHP must include in its network is limited to those needed to provide the services under its contract.

Comment: Several commenters supported the provisions at § 438.206(a) requiring that all covered services be available and accessible.

Response: We agree with the commenters and believe that these provisions are consistent with the intent of the Congress concerning the development and implementation of standards for access to care.

Comment: Many commenters said that proposed § 438.206(b) fails to provide for direct accountability by States in that it provides only that States ensure compliance *through their contracts*. These commenters believe that this wording does not require States to ensure that the contract provisions are carried out in practice.

Response: We agree with the commenter. We now specify in the regulation that § 438.206 be reflected in contracts with MCOs, PIHPs, and PAHPs, because it is essential that these requirements be included in the contract to be enforceable by the State. The regulation also requires, at § 438.204(b)(3), that States "monitor and evaluate the MCO, PIHP, and PAHP compliance with the standards".

Comment: One commenter said that a requirement that MCOs have a network "sufficient to provide adequate access to all services under the contract" is a significant departure from 1902(a)(30)(A) of the Act that requires the State to establish methods, procedures, and payments "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that

such care and services are available to the general population in a geographic area". The commenter is concerned that the language in the proposed regulation obligates the State to guarantee that all covered services are available at all times, which may be beyond the ability of the State due to shortages of service providers.

Response: Section 1902(a)(30)(A) is a requirement that applies to the State's fee-for-service program, operated pursuant to the State plan. The provision that specifically governs the availability of services under a State's managed care program is section 1932(c)(1)(A)(i) of the Act, which requires that services be available "in a manner that ensures continuity of care and adequate primary and specialized services capacity." We believe that the provisions of § 438.206(b)(1) carry out the intent of the Congress under section 1932 to provide access standards that will ensure the availability of care in MCOs, PIHPs and PAHPs.

Comment: One commenter expressed support for the provision requiring networks to have experienced providers.

Response: We agree that it is important that MCOs, PIHPs, and PAHPs have experienced providers in order to provide quality care to Medicaid enrollees. This is especially true for enrollees with special health care needs, whose needs may be sufficiently rare or complex due to multiple conditions that a provider, even one who is a specialist, may

have little or no experience in treating the enrollee's condition or conditions. Accordingly, in section 438.206(b)(1)(iii) we specify that the MCO, PIHP, or PAHP must consider the training, experience, and specialization of providers.

Comment: One commenter recommended adding language to require MCOs and PIHPs that serve children with special health care needs to include appropriately trained physicians in their network, including pediatric specialty and subspecialty physicians.

Response: We do not believe it necessary to include an explicit requirement for specific specialty and subspecialty physicians for particular groups of enrollees. The general requirement that a network be adequate to provide access to all services under the contract, taking into account the anticipated enrollment and the expected utilization, is sufficient to ensure that the network will be adequate to meet all needs. Inclusion of language related to particular groups may even be detrimental in that it would be impossible to list the particular requirements of all groups.

Comment: One commenter suggested that we add an explicit requirement that MCOs and PHPs pay particular attention to the needs of enrollees with disabilities when developing and maintaining networks. Without such a provision, the commenter is concerned that specialized psychiatric treatment for children and adults with severe mental illness may

not be available. The commenter believes that the inclusion of such a requirement has the potential

* * *